

**DRAFT**  
**BOARD OF HEALTH PROFESSIONS**  
**REGULATORY RESEARCH COMMITTEE**  
**PUBLIC HEARING ON EMERGING PROFESSIONS**  
**AUGUST 11, 2009**

**TIME AND PLACE:** The public hearing was called to order at 9:08 a.m. at the Department of Health Professions. The purpose for the hearing was to receive public comment pursuant to its study into the need to regulate the emerging professions: Surgical Assistants and Surgical Technologists.

**PRESIDING CHAIR:** Damien Howell, P.T.

**MEMBERS PRESENT:** Jennifer Edwards, Pharm.D.

**STAFF PRESENT:** Elizabeth A. Carter, Ph.D., Executive Director, Board of Health Professions  
Justin Crow, Research Assistant  
Carol Stamey, Operations Manager  
Laura Chapman

**OTHERS PRESENT:** David Jennette, CSA  
Helen French, RN, BSN  
Rebecca Music, AD, CST  
Sandra Luthie  
Stephen Balog, RN  
Bonnie Vencill, RN, CNOR  
Becky Bowers Lanier  
Julie Vaughn  
James E. Jones, Jr.  
Juan M. Montero, II, MD  
Theresa Cooper, CFA, CSA, CST  
Mary Armstrong, CSA, CFA, CST  
Cathy Sparkman  
Matt McBee, MD  
Mary C. Flynn  
Suzanne Cunniff  
Thomas Hegens  
Michael A. Ouden  
Jake Jacobs  
Zina Sutton  
Kary Simons Reed  
Heather Wooldndge, VA Hospital Healthcare Assoc.

Joseph Dalto  
R. Clinton Crews, VASA  
Darryl Moss  
Fay Fellows  
Michele Hughes  
Lisa Kear  
Yolanda Y. Williams, JTCC

**COURT REPORTER:**

Lynn Aligood, Capitol Reporting, Inc.

**PUBLIC COMMENT:**

David Jennette, CSA, Sentara Hospital, President of National Surgical Assistant Association, complimented Mr. Crow on his performance of the emerging professions research project. Mr. Jennette stated that a petition of surgeons had been conducted and 300 physicians had signed the petition in favor of licensure of certified surgical assistants. Further, he noted that the petition included the signed signatures of the Chairman of the American Medical Association, Nancy Nielson, MD and Juan Montero, MD.

Helen French, RN, spoke in favor of the required registration of surgical assistants and surgical technologists. Ms. French provided a written statement and it is incorporated into the minutes as Attachment 1.

Rebecca Music, CST, presented a DVD that demonstrated the job functions of surgical assistants and surgical technologists involved in a live knee surgery case. Additionally, interviews were conducted with nurses, medical doctors, surgical technologists and surgical assistants. Ms. Music favors regulation.

Sandra K. Luthie, UVA Medical Center, CST, spoke in favor of regulation.

James E. Jones, Jr., MD, St. Mary's OB-GYN, spoke in favor of the regulation of surgical assistants and surgical technologists.

Stephen Balog, RN, CNOR, Virginia Council of periOperative Registered Nurses, spoke in favor of certification, not licensure, of surgical assistants and surgical technologists. Additionally, he requested clarification of scopes of practice as outlined in his written

comment incorporated into the minutes as Attachment 2.

Bonnie Vencill, RN, CNOR, AORN Legislative Coordinator, spoke in favor of certification of surgical assistants and surgical technologists. Ms. Vencill's written comment is incorporated into the minutes as Attachment 3.

Becky Bowers-Lanier, Virginia Nurses Association, spoke in favor of certification or some type of regulation of surgical technologists. With regard to the surgical assistants, she stated that the VNA took no position on the need for regulation. Ms. Bowers-Lanier also noted concerns with overlapping roles and scope of practice of the two groups.

Julie Vaughn, CST, spoke in favor of licensure of both the surgical assistants and surgical technologists.

Matthew McBee, MD, General and Vascular Surgery, spoke in favor of licensure of surgical assistants and surgical technologists.

Juan Montero, II, MD, retired cardiac and thoracic surgeon, spoke in favor of the need to license surgical assistants.

Theresa Cooper, CFA, CSA, spoke in favor of the need to regulate surgical assistants.

Catherine Sparkman, Esquire, Director of Public Affairs, provided an update on the various states' proposed legislation to license surgical assistants. Additionally, she presented her findings on post traumatic infections, provided data on the roles of surgical assistants, a listing of schools and graduates and a list of "never events" that Medicare declines to pay.

Mr. Howell informed the public that the deadline to submit written comment is August 15, 2009.

The public hearing transcript will be incorporated into the minutes as Attachment 4 upon receipt from Capital Reporting, Inc.

**ADJOURNMENT:**

The Hearing adjourned at 10:20 a.m.

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Damien Howell, P.T.  
Chair

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Elizabeth A. Carter, Ph.D. Executive Director  
Board of Health Professions

Attachment 1

AUGUST 11, 2009

FROM: HELEN FRENCH RN,BSN

www.OPERATINGRoomRN  
watchingoveryou.com

TO: VIRGINIA BOARD OF HEALTH PROFESSIONS MEMBERS AND ET  
AL

RE: COMMENTS REGARDING: "AN ONGOING REVIEW OF  
EMERGING  
HEALTH PROFESSIONS" I. E. "SURGICAL ASSISTANTS AND  
SURGICAL  
TECHNOLOGIST S"

Historically, all National Boards of Health Professionals, as in Virginia, main job is to "ensure that patients receive continuous safe and competent care in the healthcare arena"

Legally and ethically, I, as a Registered Nurse licensed in Virginia, am held to the oath that I "do no harm". For 33 years, I had been a competent RN. Never, in my 33 years of working in the operating room arena have I had a patient incident.

My first response to this "issue" today is, "Why have not these "two" professions been regulated from the genesis? I am personally troubled by the "lack" of any regulations on these two groups, especially since over many years, the Registered Nurse especially the "Registered Nurse Operating Room Circulator", the RN most often present or absent per hospital policy in Virginia, fought very hard legislatively to make sure that all patients in the operating room, etc i.e. where a patient was undergoing invasive procedures, had a RN with them for the entire length of the case or procedure. No one should enter any OR Room or Procedure Room where there is no ORRN Circulator present for the entire case or procedure especially IF the rest of the staff, besides the surgeon and / or anesthesiologist or the CRNA , are UAPs ( unlicensed assistive personnel ).

In this day and time, when even hairdressers are required to be licensed, my opinion is that because the "above" topic is very misunderstood and is very critical to all patients safety under going "invasive procedures", that "Surgical Assistants and Surgical Technologists" be considered for only the legal status of REGISTRATION in the State of Virginia. In order to further ensure the safety and welfare of all patients in Virginia, besides BEING GRANTED the legal status of REGISTRATION, all legal verbiage should also reflect that in Virginia, Surgical Assistants and Surgical Technologists always work "under the direct supervision of

HF

**the surgeon and the Operating Room Registered Nurse Circulator at all times for the duration of a patient's invasive procedure / case.**

**In "both cases" a main issue is the *Lack of Standardization* of: education, titles, roles, and even job descriptions at hospital level.**

**The terms Surgical Tech and Surgical Assistant ( i.e an UAP ) encompasses too many TITLES i.e. Sa, First Assistant, ST, CST, CSTFA, TECHs ( trained on the job), six month course, 12 month course, associate degree, diploma, certification and LPNs and aides who are hired as TECHs and etc.**

**( CST could also mean Central Supply Technicians )**

**I have read the entire DRAFT on the "issue".**

**I have research web sites especially the American College of Surgeons, AST, and etc. I have read the "SEVEN" Standard Evaluative Criteria.**

**I agree that "REGISTRATION" of Surgical Assistants and Surgical Technologists in Virginia is critical because:**

- 1. Due to the fact that the Surgeon is no longer the Captain of the Ship, legally nor realistically ( legal cases usually do not up hold the "Captain of the Ship" philosophy and the fact that surgeons during the day often work in multiple OR rooms .....meaning, that they can not and are not present in one room for the entire case, means it is very important that it is the OR RN Circulator, a licensed RN, who then is present for the entire length of the case / procedure ) \* For example, when a surgeon does 22 eye cases in one day, it means ONLY one thing.....the cases are not performed in the same room all day with the same staff!**
- 2. Due to WEAK CMS regulatory verbiage i.e. 482.51 per se, "states" do not have to have one ORRN Circulator in each room.....CMS leaves the interpretation to the states! AND JUST because the VIRGINIA DELEGATION reg #6 states that: "circulating duties can not be delegated, and just because it is written, does NOT mean that hospitals are following the verbiage in the regulations. In fact, nurses just questioned me about this FACT.....until I sent them the VA / BON verbiage! The nurses were unaware of reg \* under "delegation". Also, some hospitals are "satisfying" some of the CMS verbiage by the nature of having that "ONE" RN being the "RN scrub nurse or the RN FA or the CRNFA." No RN can supervise or delegate from any SCRUB position .....one can not ever take one's eyes off of the surgical field.....even for a second!**
- 3. Due to a power struggle by the TECHs which I have seen and read about and because of comments made by AST organization such as it: "rejects any suggestions or inferences that surgical technologists are nursing assistive personnel and that nursing has the right to dictate the scope of practice of the professions"....." indicates and proves that they are not team players but**

*HY*

only indicates their passion for overlapping their roles in the operating room arena and where invasive procedures / cases are performed. This type of attitude could endanger patients! (\* where does the reg of a non certified aide assisting on surgical cases come under ????)

4. Due to the fact that there is NO one national standard test for SAs or for STs as there is for RNs i.e. the NCLEX test which allows for ONE basic standard of nursing quality, REGISTRATION of SAs AND STs is the only possible route for ensuring patients safety in Virginia.....The state of Virginia can only REGULATE what it can MEASURE!
5. Due to the fact there is no National Data Bank for SAs or STs, REGISTRATION is the only possible route for ensuring patient safety
6. Due to the CRITICAL nature of SAs and STs TRAVELERS going from state to state all year except for one month of the year where upon they go home to fulfill Federal Tax Residency requirements.....one never knows WHO KNOWS WHAT.....and then one would hear TECHs state, ' I don't do eyes, or I don't do hearts, and etc.....' RNs are not given the SAs or STs Agency records each time a RN works with a UAP ( TECH )  
\*\*\* Virginia should look at "charging / taxing" travelers.....one Masters prepared nurse just told me that she receives \$30.00 an hour where a Travelers received \$70.00 an hour.....plus "they" receive free housing or a 1000.00 + housing stipend, all utilities except phone paid, 401, bonuses etc etc
7. Due to the fact, that some TECH "educational " organizations are accredited and some are not, also indicates that TECHs ( UAPs ) should only be REGISTERED! RNs in Virginia could not take their NCLEX if their "school" was not accredited!
8. JCAHO does not mandate a ORRN Circulator or any RN to be in the operating room i.e. on invasive procedures. I find this personally UNSAFE! My question of all board members is, " Would you want to be a patient in the ICU with a RN? *No surgical case is simple!* ALL nursing tasks do require "critical nursing thinking, assessment, evaluation and etc "!

Example scenario: during a "simple" hernia surgery a femoral artery was tied off.....the man would have had to have his leg amputated if not a ORRN Circulator noticed that there was poor perfusion in the "leg". The wound was opened and the surgery was re done!

Example scenario: ask a UAP, "In what situation" would the surgeon need a 6-0 silk?

Example scenario: AST "states" that a UAP can ' push / advance " the colonoscope. I personally have been in on cases to "repair" a colon" because the "colon" was ruptured during a scoping.

Example scenario: I have hundreds of stories.....

*HK*

**In conclusion but not final, again I strongly suggest that SAs and STs MUST only be REGISTERED and continue to work under the DIRECT supervision of the SURGEON and OR RN Circulator.**

**REGISTRATION should include;**

**Name**

**Address**

**Phone number**

**Home state**

**Work history ( chronologically )**

**Area of Specialty**

**Areas worked in**

**Education ( was school accredited? )**

**Certification and year of**

**Any military service and certification and discharge papers**

***TOO MANY "SURGICAL TECH" TITLES:***

**CORST ( CERTIFIED OR ST )**

**ST ( SURGICAL TECH )**

**CST ( CERTIFIED SURGICAL TECH )**

**TS-C ( TECH IN SURGERY CERTIFIED )**

***TOO MANY "SURGICAL ASSISTANT TITLES":***

**CSA ( CERTIFIED SURGICAL ASSISTANT )**

**PA-C ( PHYSICIAN ASSISTANT – CERTIFIED )**

**SA ( SURGICAL ASSISTANT )**

**SA-C ( SURGICAL ASSISTANT –CERTIFIED )**

***PER COLLEGE OF SURGEONS, WHO USES "FIRST ASSISANT" AND "ASSISTANT" TERM INTERCHANGEABLY, I.E. "CFA" OR "CSA"***

***CFA ( CERTIFIED FIRST ASSISTANT )***

***CSA ( CERTIFIED SURGICAL ASSISTANT )***

**\*\*\*\*\*  
\*\* Per Dr., Rusch's comment made in 2000 / American College of Surgeons  
/ Board of Governors, "We need to assure that surgery is done by surgeons  
\*\*\*\*\***

*HP*

## ORAL STATEMENT TO READ FROM

My name is Stephen Balog RN, MSN, CNOR and I am the Chair of the Virginia Counsel of periOperative Registered Nurses (VCORN) representing over 1300 periOperative registered nurses in Virginia. I am currently working as a Clin 5 staff nurse in the Cardio-vascular Operating Room at Virginia Hospital Center. I have worked in the Operating Room for 31 years. 28 years as a periOperative registered nurse and 3 years as a LPN/ST. I have held positions from scrub nurse to director of Surgical Services in my career.

Thank you for providing VCORN with the opportunity to present testimony today on this very important effort to evaluate the emerging role of the surgical technologist in Virginia. Our comments today and the statement for the record that we submitted in a letter dated July 6, 2009 are based on our experience as periOperative registered nurses working with surgical technologists toward a goal of patient safety. Our concern with the potential for public harm underscore our comments as we are guided by the policies of our national organization – the Association of periOperative Registered Nurses (AORN).

As you evaluate the potential risk for harm to the consumer, we encourage you to consider “Certification” as it requires a minimum level of competency but also recognizes that the emerging function of surgical technologist is not a practitioner that could practice autonomously. Licensure is inappropriate.

However in the description of Voluntary Certification <sup>on</sup> at page 46 it states that “The scope-of-practice is not restricted...” and the Certification “does not restrict the performance of duties only to those certified.” We counsel caution on these terms as we consider “practice” too enabling or potentially expansive and prefer “range of function.” Moreover we believe the scope of practice should be specifically limited to those identified on page 11 with the exception that #3 the reference to medication needs to be clarified further.

The range of function of the surgical technologist is distinguishable from the registered nurse and as indicated on page 5 of the summary “In the state of Virginia, a registered nurse must act as circulator and the registered nurse

may not delegate tasks associated with the circulator role, limiting surgical technologists to the role of the scrub person." We might add that the Summary contains references that are not consistent with the above statement and therefore for purposes of clarification such incorrect references should be corrected prior to finalizing the Staff's Summary report.

In the interest of time I would like to summarize <sup>5</sup>~~four~~ recommendations that we have:

- 1) Clarify throughout the Summary of Staff Research to be consistent with: "In the state of Virginia, a registered nurse must act as circulator and the registered nurse may not delegate tasks associated with the circulator role, limiting surgical technologists to the role of the scrub person" that is identified on page 5
- 2) Clarify the Scope of Practice on page 11 to be restated as "Range of Functions" as this term is recommended from the Glossary from the National Council of State Boards of Nursing; the functions listed in #3 should be clarified such that medication can be transferred but not administered; the section on "circulating surgical technologist functions" should be deleted except to restate the sentence: "In Virginia, a registered nurse must function as circulator and may not delegate circulator duties."
- 3) AORN and AST policies disagree on the independence of surgical technologists and the need for the surgical technologist to be supervised by the registered nurse. AORN Policy, consistent with Medicare conditions for coverage, facility policy that is compliant with Medicare, and with the Table 1 in the Summary all identify the need for the registered nurse to supervise the surgical technologist.
- 4) VCORN supports Certification of the Surgical Technologist function that is consistent with the AORN Legislative Principles to be used in evaluating Allied Health Legislative Initiatives.
- 5) Recommend that the review of the Surgical Technologist and the Surgical Assistant need to be separated. These 2 groups of allied health personnel perform completely different functions and they should not be compared/contrasted in the same document.

6)

We will be happy to answer questions from the committee and ask that the following documents be added to the committee record for this hearing:

- 1) AORN Position Statement on Surgical Technologists
- 2) AORN Legislative Principles regarding Allied Health Personnel
- 3) AORN Position Statement on the Role of the Scrub Person
- 4) AORN Glossary of Terms for Legislative Principles on Allied Health Legislation

Testimony  
of the  
Virginia Council of periOperative Registered Nurses  
by  
J. Stephen Balog RN,MSN, CNOR; Chair VCORN  
Bonnie P. Vencill RN, CNOR: AORN State Coordinator  
Before The  
Virginia Board of Health Professions  
Virginia Department of Health Professions  
On  
Surgical Assistants & Surgical Technologists  
August 11, 2009

Summary of Recommendations

- 1) Clarify throughout the Summary of Staff Research to be consistent with:  
“In the state of Virginia, a registered nurse must act as circulator and the registered nurse may not delegate tasks associated with the circulator role, limiting surgical technologists to the role of the scrub person” on page 5
- 2) Clarify the Scope of Practice at page 11 to be restated as “Range of Functions” recommended from the Glossary from the National Council of State Boards of Nursing; the functions listed in #3 should be clarified such that medication can be transferred but not administered; the section on “circulating surgical technologist functions” should be deleted except to restate the sentence: “In Virginia, a registered nurse must function as circulator and may not delegate circulator duties.”

- 3) That AORN and AST policies disagree on the independence of surgical technologists and the need for the surgical technologist to be supervised by the registered nurse. AORN Policy, consistent with Medicare conditions for coverage, facility policy that is compliant with Medicare, and with the Table 1 in the Summary all identify the need for the registered nurse to supervise the surgical technologist.
- 4) VCORN is concerned with the potential for public harm and thus supports Certification of the Surgical Technologist function that is consistent with the AORN Legislative Principles to be used in evaluating Allied Health Legislative Initiatives.
- 5) Recommend that the review of the Surgical Technologist and the Surgical Assistant need to be separated. These 2 groups of allied health personnel perform completely different functions and they should not be compared/contrasted in the same document.

Thank you for providing VCORN with the opportunity to present testimony today on this very important effort to evaluate the emerging role of the surgical technologist in Virginia. Our comments today and the statement for the record that we submitted in a letter dated July 6, 2009 are based on our experience as perioperative registered nurses working with surgical technologists toward a goal of patient safety. Our concern with the potential for public harm underscore our comments as we are guided by the policies of our national organization – the Association of periOperative Registered Nurses (AORN).

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As you evaluate the potential risk for harm to the consumer, we encourage you to consider “Certification” as it requires a minimum level of competency but also recognizes that the emerging function of surgical technologist is not a practitioner that should practice autonomously. Licensure is inappropriate.

However in the description of Voluntary Certification at page 46 it states that “The scope-of-practice is not restricted...” and the Certification “does not restrict the performance of duties only to those certified.” We counsel caution on these terms as we consider “practice” too enabling or potentially expansive and prefer “scope of function.” Moreover we believe the scope of

practice should be specifically limited to those identified on page 11 with the exception that #3 clarify reference to medication.

The scope of function of the surgical technologist is distinguishable from the registered nurse and as indicated on page 5 of the summary "In the state of Virginia, a registered nurse must act as circulator and the registered nurse may not delegate tasks associated with the circulator role, limiting surgical technologists to the role of the scrub person." We might add that the summary contains references that are not consistent with the above statement and therefore for purposes of clarification such incorrect references should be corrected prior to finalizing the summary report.

We will be happy to answer questions from the committee and ask that the following documents be added to the committee record for this hearing:

- 1) AORN Position Statement on Surgical Technologists
- 2) AORN Legislative Principles regarding Allied Health Personnel
- 3) AORN Position Statement on the Role of the Scrub Person
- 4) AORN Glossary of Terms for Legislative Principles on Allied Health Legislation

My name is Bonnie Vencill RN, CNOR and I am the Legislative State Coordinator for Virginia/DC. I am a member of both the Virginia Council of Perioperative Registered Nurses (VCORN) and the Association of Perioperative Registered Nurses (AORN). I currently am employed at Southside Regional Medical Center in Petersburg, Virginia in the operating room. I have thirty years of perioperative nursing experience.

Thank you for allowing Steve and I to participate in this very important issue concerning the certification of surgical technologists and surgical assistants. Our letter dated July 6, 2009 has been forwarded and received by the board of health professions.

The surgeon, anesthesiologist, surgical assistant, scrub technologist and circulating Registered Nurse all work as a team to insure the safest environment and best outcome for each of our patients in the operating room. We do believe that surgical technologists should be graduates of accredited education programs and/or have successfully completed a national specialty certification process. This will provide that the "scrub" delegated roles are filled with qualified and capable staff.

To this end, we believe the perioperative Registered Nurse (circulating nurse) by her credentials, education and experience must remain as the patients advocate and ensure each patients safe outcome. The professional Registered Nurse must oversee the entire surgical process and anticipate the needs for each surgical patient and case. In Virginia, a Registered nurse must function as "circulator" and <sup>may</sup> not delegate circulator duties.

AORN and AST policies disagree on the independence of surgical technologists and the need for the surgical technologist to be supervised by the Registered nurse. AORN policy, consistent with Medicare conditions for coverage, facility policy that is compliant with Medicare all identify the need for the registered nurse to supervise the surgical technologist.

VCORN is concerned with the potential for public harm and thus supports Certification of the Surgical Technologist function that is consistent with the AORN Legislative Principles to be used in evaluating Allied Health Legislative Initiatives.

In conclusion, we are guided by the policies of our national organization- the Association of periOperative Registered Nurses (AORN). If you have further questions or need any other information please feel free to contact me.

Respectfully submitted,

Bonnie P. Vencill, RN, CNOR  
AORN Legislative Coordinator VA/DC

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DEPARTMENT OF HEALTH PROFESSIONS

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PUBLIC HEARING IN RE:

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THE NEED TO LICENSE SURGICAL ASSISTANTS  
AND  
SURGICAL TECHNOLOGISTS

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9960 Mayland Drive  
Board Room 4  
Richmond, Virginia

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August 11, 2009  
9:00 a.m.

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CAPITOL REPORTING, INC.  
P.O. Box 959  
Mechanicsville, Virginia 23111  
Tel. No. (804) 788-4917

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CAPITOL REPORTING, INC.'

## 1 APPEARANCES:

2 Damien Howell, P.T. - Chairman

3 Elizabeth A. Carter, PhD - Executive Director for Board

4 Justin Crow - Research Assistant

5 Carol Stamey - Operations Manager

6 Laura Chapman

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## S P E A K E R S:

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David Jennette

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Helen M. French

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Rebecca Music

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Sandra K. Luthie

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James E. Jones, Jr, M.D.

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Stephen Balog

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Bonnie Vencill

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Becky Bowers-Lanier

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Julie Vaughn

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Matthew McBee, M.D.

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Juan M. Montero, II, M.D.

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Theresa Cooper

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Mary Armstrong

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Cathy Sparkman

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MR. HOWELL: Good morning. I'm Damien Howell, chair of the Regulatory Research Committee. This is a public hearing to receive public comment on the board's study for emerging professions of surgical assistants and surgical technologists.

We have just a bit of housekeeping to start with. First if you have cell phones and stuff on, appreciate it if you put them on silent mode.

NOTE: Emergency evacuation instructions are given by Dr. Carter.

MR. HOWELL: While you have the microphone, we expect the rest of the committee members to come in shortly. We will recognize them when they sit with their name tags. I'd like to take a moment to introduce the rest of the staff.

NOTE: Staff introduces themselves as follows: Elizabeth Carter, Executive Director for the Board, Carol Stamey, Operations Manager for the Board, and Laura Chapman, soon to be operations manager as we go through the transition later on in October, Justin Crow, Research Assistant to the Board.

MR. HOWELL: The Code of Virginia

1 authorizes the Board of Health Professions to advise  
2 the Governor, the General Assembly, and the department  
3 director on matters related to the regulation of health  
4 care occupations and professions. Accordingly the  
5 board is conducting this study and will provide  
6 recommendations on whether there is a need for  
7 regulation.

8 At this time I will call on persons who  
9 have signed up to comment. As I call your name, please  
10 come forward and tell us your name and profession, what  
11 you wish to speak about, and where you are from. And  
12 we do have a large number of people requesting to  
13 speak, so please be efficient. I'm going to limit you  
14 to 5 minutes each person. And we have that list. I  
15 will go down the list in order of signing up to speak.  
16 If you signed up on the wrong list and don't want to  
17 speak, just let us know.

18 David Jennette.

19 MR. JENNETTE: Good morning. Again thank  
20 you for having me here today.

21 My name is David Jennette. I live in  
22 Suffolk, Virginia. I'm a certified surgical assistant.  
23 I live in Suffolk, Virginia and work there at Sentara  
24 Obici Hospital, and I won't go over 5 minutes. I don't  
25 want to repeat some of the things that we said in the

1 past, but I do want to commend Mr. Crow on a job well  
2 done on the survey last summer that he's already done.  
3 It's very good, and it is accurate data, and I'm sure  
4 it's enough information to determine appropriate level  
5 of regulations.

6 I do, however, have a stack of petitions,  
7 looks like almost 300 that we did a little impromptu  
8 experiment with of surgeons, specifically surgeons who  
9 are in favor of licensure for surgical assistants and  
10 the ones who we work with and who watch our every move.

11 I will not mention any of the surgeons'  
12 names on the list but I do want to recognize that  
13 included on one of the lists is the Chairman of the  
14 American College of Surgeons, Board of Regents,  
15 Dr. L.D. Britt, and it's well, with all of these  
16 surgeons' names, they fully support regulation for  
17 surgical assistants by way of licensure, and we'll  
18 gladly entertain questions and offer advice to the  
19 board if so needed. Also like to point out that on one  
20 of the petitions Dr. Montero has signed his support as  
21 well.

22 So I hope this level of support helps on  
23 your decision. These are the physicians that are the  
24 professionals that were responsible for bringing the  
25 patients into the hospital and that allow us to assist

1     them. And that's all I have, and take any questions if  
2     you have any.

3                     MR. HOWELL: Thank you. Helen French.

4                     MS. FRENCH: Good morning. My name is  
5     Helen M. French and I thank the board here for letting  
6     me or allowing me to sign up to speak today on a  
7     subject that covers basically the whole operating room  
8     issues, and especially the one on the board today about  
9     the regulation of surgical assistants and surgical  
10    technologists.

11                    I want to, and I want to give you just a  
12    couple little quotes besides letting you know that I  
13    have been an OR nurse for over 33 years, I have a long  
14    resume', and I am not for techs, nurses, et cetera, et  
15    cetera, or against nurses, techs or anybody. My main  
16    issue for being here today is to make sure that there  
17    is the safety of a patient in Virginia and in the  
18    United States is considered first and foremost, okay?  
19    And you can look at my web site, and I wrote that down  
20    on a piece of paper, I have 4 pages, I encourage board  
21    members to get from Carol, please.

22                    I'm a patient safety advocate, number  
23    one, and finally I want to just give you a couple  
24    little, I have done my research unlike some of the  
25    federal people who haven't read the thousand pages. I

1 have been doing research for my whole 35 years that I  
2 have been a nurse per se, okay? I just want to bring  
3 out a couple points, and these are points that need to  
4 be considered when everybody is trying to decide on  
5 this issue. Licensure or regulation, i.e., the  
6 regulation, i.e., licensure or registration. I am for  
7 registration for the techs. I think this is to their  
8 best interests. And again I'm not against or for  
9 anybody. It's my patients who I have worked hard for.

10                   Number one, the American College of  
11 Surgeons says, and I'm just going to briefly say these  
12 things, and I speak fast, so I apologize for that, but  
13 number one, surgical assistants, quote, unquote, from  
14 the College of Surgeons statement on principles are:  
15 Essays now are surgical assistants are not authorized  
16 to operate independently. Another comment by American  
17 College of Surgeons: Surgical techs are individuals  
18 with specialized education, et cetera, et cetera, who  
19 are suppose to work in the role of scrub person. With  
20 additional education and training some can function in  
21 the role of first assistant. Unless you work in the  
22 OR, there are so many titles and so many roles that  
23 overlap, I'm afraid nobody really knows who is doing  
24 what. For the RN's sake, for the tech's sake, for  
25 everybody's sake, people need to know who is who at an

1 operating room table.

2 Another thing from the American College  
3 of Surgeons: Only qualified surgeons who carry high  
4 surgical care for the sick and injured, and Dr. Rush  
5 who is on the Board of Governor's said, 2006: We have  
6 to make sure that surgery is performed by surgeons,  
7 okay? Amen, that's what I'm saying on that.

8 AST, Association of Surgical  
9 Technologists says, and this is what bothers me, and I  
10 think this discredits their whole group and I think  
11 they, the techs present here today, the SAs and techs  
12 present here today should really have a verbiage change  
13 here. It says the Association of Surgical  
14 Technologists reject any suggestion or inference that  
15 surgical technologists are nursing assistant personnel,  
16 which they are not, and nursing has the right to  
17 dictate the scope of practice of the profession.  
18 Everybody has to have their own job description per se,  
19 but again if you don't have national standards, who  
20 knows what the standards are? You cannot let the  
21 hospitals mandate job descriptions or standards. You  
22 have to have a national standard again for the safety  
23 of the patient.

24 This has caused, this sentence right  
25 here, has caused a power struggle in the OR, which

1 shouldn't be. OR is a team effort. The surgery, all  
2 surgeries small or large, and there is no such thing as  
3 a simple case, are surgery. This is what they say, and  
4 I think they explain, this is insightful I think on  
5 their part and they shouldn't be saying it, but AST  
6 preferred model for entry for a surgical first  
7 assistant is recommended as a Bachelor's degree. The  
8 job description for ASA again for surgical assistant,  
9 surgical assistant performs these functions, quote  
10 unquote: During the operation under the direction and  
11 supervision of a surgeon and in accordance with  
12 hospital policy and appropriate laws and regulations.

13               So I'm just trying to show you, I'm not  
14 going on to CAAHEP, again to the discredit of techs,  
15 there's so many groups and organizations that are  
16 accredited and not accredited. As a nurse I wouldn't  
17 have been able to take my nursing exam, my RN exam if I  
18 came from a nursing school that wasn't accredited, so,  
19 you know, techs should also fight for this right, say  
20 hey, we don't want this, you want to be valid.

21               Associate degree, according to AST, is  
22 they say that an associate degree is the preferred  
23 educational model for entry level practice. AST,  
24 surgical technologist job description, surgical  
25 technologists work under the supervision of a surgeon.

1 This is all from their site. My question always is my  
2 God, what happens when the surgeon is not here? It's  
3 not like it use to be when I first got into nursing.  
4 Surgeons would stay from the beginning to the very end  
5 until that dressing is on and then follow the patient  
6 to the recovery room. It's not done that way. They  
7 have gone to the room. One hospital, they are doing 22  
8 eye cases a day. How is that doctor, and I'm not being  
9 mean spirited, he cannot be everywhere, so --

10 MR. HOWELL: Can I ask you to summarize?

11 MS. FRENCH: Okay, I'm going to  
12 summarize. Is it 5 minutes already? I should have had  
13 my timer. Okay. Well, I'm sorry.

14 I just feel, number one, because of  
15 federal rule CMS482.51 says that a registered nurse,  
16 the registered nurse OR circulator should be the person  
17 in the OR as the RN. They don't even talk about RNSA  
18 or CRNSAs or any advanced practice things for the  
19 nurses, but there needs to be an RN in the OR, okay?  
20 But then it says, and they defer it and weaken the  
21 language by saying but if the hospital says you don't,  
22 if you don't have an RN, there has to be one in  
23 supervision. She could be having a cup of coffee 2  
24 blocks away.

25 Basically the point is if there's no RN,

1 then you have unregulated people in the OR, which again  
2 then they need to have a regulated title, then who is  
3 in charge? The doctor is not everywhere, okay? And he  
4 needs help. It is, everybody is a team in the OR,  
5 nobody is a lone ranger, and it shouldn't be a squabble  
6 about job roles and job descriptions or anything else.  
7 We need to think about what can happen to patients, and  
8 anything can happen quickly, and we all know that. I'm  
9 sure many of you have been on a case, scrubbed in, and  
10 all of a sudden the injection went into an artery when  
11 you are doing an eye case, went into the retrobulbar  
12 space. Well, the patient coded. You have got to have  
13 people and RNs and techs, all the people to make sure  
14 when you are in the OR, you need to have the best staff  
15 possible, and not hospital aids per se maybe all of a  
16 sudden cleaning the floor then doing a C-section.

17 MR. HOWELL: I hate to interrupt you, can  
18 I help you summarize to say that you are in favor of  
19 registration?

20 MS. FRENCH: I am for their own sake and  
21 for the whole team's sake and to end some of this  
22 squabbling and for patient's safety. I have tons of  
23 data on any issue as far as of the operating room, and  
24 I will gladly share it with anybody so they can make  
25 good decisions for everybody. Thank you.

1 MR. HOWELL: Love to have you submit this  
2 data in writing, because there will be a period for  
3 public written comment as well until the 15th of  
4 August.

5 MS. FRENCH: Thank you.

6 MR. HOWELL: Thank you. Next on the list  
7 is Rebecca Music.

8 MS. MUSIC: Yes. Good morning, fellow  
9 board members, DHP board members, thank you so much for  
10 convening again and allowing us to present to you some  
11 fascinating information and very heartfelt and  
12 passionate discussion about the need to regulate the  
13 professions of surgical assisting and surgical  
14 technology. I also want to thank all of the audience  
15 who was able to take off today and show their support  
16 for this cause. It is truly important and it's time.

17 My name is Rebecca Music. I'm a  
18 certified surgical technologist with an associate's  
19 degree. I'm here from, I live in Virginia Beach but I  
20 work in Portsmouth, Virginia at the Naval Medical  
21 Center in Portsmouth. I'm here on behalf of surgical  
22 technologists.

23 I have a short mini DVD that I'm going to  
24 present, and if I have any time after that, I'll just  
25 say a few quick words and answer any questions.

1                   NOTE: Speaker plays DVD at this point in  
2                   her presentation as follows:

3                   Jessica Harman, I am a surgical tech in  
4                   the United States Navy currently working at the medical  
5                   center in Portsmouth at the main OR. I have very many  
6                   different perspectives of being a surgical tech. I  
7                   have seen very many different ways they have been  
8                   treated, and I believe that our role is very important.

9                   MS. MUSIC: Total knee surgery is going  
10                  on here, total knee replacement.

11                  AUDIENCE MEMBER: Talk us through it.

12                  MS. MUSIC: What would you like to know?

13                  NOTE: Audience member and speaker on DVD  
14                  speak at the same time, and then the speaker  
15                  on the DVD continues as follows:

16                  Stephanie Hines, I'm a registered nurse  
17                  in one of Virginia's largest military hospitals, and I  
18                  have been a, in the operating room for a long time. I  
19                  spent my first 10 and a half years in the operating  
20                  room as a surgical technologist, and I just wanted to  
21                  share a statement about a critical role that the  
22                  surgical technologist plays in the operating room.

23                  The operating room is, it's a very  
24                  volatile environment with very precise procedures, very  
25                  technical equipment, and the surgical technologist

1 brings with them knowledge of anatomy and physiology  
2 and procedures, infection control, and that combined  
3 with their technical skill and ability really  
4 contributes to the OR team's ability to facilitate the  
5 best possible outcomes for the patients that we serve,  
6 and their knowledge and their expertise is essential.  
7 I would not want to be a perioperative nurse in the  
8 operating room and not have my surgical techs by my  
9 side to help in that process.

10 I'm Dr. Allen Mitchell, I'm a surgical  
11 oncologist at a medical center in Virginia. Surgical  
12 technologists are important because whether you are  
13 doing a simple or complicated case, you require the  
14 assistance of a professional who has the expertise and  
15 ability to respond to changing situations. This allows  
16 the treatment of emergencies rapidly, as well as the  
17 ability to do routine cases quickly and precisely.

18 MS. MUSIC: Someone mentioned they wanted  
19 me to kind of talk through the video. This is a  
20 surgical technologist, a certified surgical  
21 technologist performing his job. This is after the  
22 count has been performed, they are the process of doing  
23 the case. The knee is opened, you can see surgeons and  
24 folks up there and the surgical assistant taking tissue  
25 away from the knee, from the patella. The surgical

1 tech there is maintaining the sterile field. He is  
2 managing his sterile field. He has a double decker  
3 back table which has to be set up completely by the  
4 surgical technologist that's scrubbed in. There's  
5 typically no help for setting up those tables and  
6 things of that nature.

7 NOTE: Speaker on DVD and Ms. Music are  
8 speaking over each other briefly, and then  
9 the tape continues as follows:

10 I'm at the Naval Hospital in Portsmouth,  
11 Virginia. I was a surgical technologist in the Navy,  
12 and a dental assistant in the Navy. I believe being a  
13 surgical technologist is a very important job. We help  
14 assist the surgeon in cases. Patient care comes first,  
15 take the job seriously, you have to trust in yourself,  
16 know medical technology and pay attention to the  
17 patient. Attention to detail is a key point in this  
18 job, listening to the nurses, your anesthesiologist,  
19 and just stay on top of education, always educate  
20 yourself and stay aware of new technology with this  
21 job.

22 MS. MUSIC: That's the end of the mini  
23 DVD or movie that I put together for presentation, and  
24 I also gave a copy to Mr. Crow for submission, but I do  
25 want to say a few things in closing, and I would not

1     only like to address the board, the HP board but also  
2     members of the audience.

3                     Surgical techs, this is our time, and we  
4     need to bond together to make this happen. Yes, it's a  
5     team effort, but with anything that's worth having,  
6     it's worth fighting for, so we need to band together  
7     for this issue, dig in our heels, and do what it takes  
8     to get the job done. We shouldn't be talking any more  
9     about I'm scared to take a test or things of that  
10    nature because it is about patient safety. Patient  
11    care comes first, and we know what we are doing.

12                    To the RNs in the audience, we are a  
13    health care team in that OR. We are an army of one.  
14    That's the Army's new motto. Now I say that in any  
15    organization in which you have many different people on  
16    one team, we are an army of one for that one patient.  
17    We rally around that patient. We are not asking you to  
18    disappear, we are not asking you to, you know, not  
19    delegate anything to us, but for decades surgical techs  
20    have been able to educate ourselves, we have been able  
21    to manage ourselves, and we do have some autonomy in  
22    our profession. Yes, we have a certain hierarchy in  
23    the ORs, and I think as Helen mentioned earlier, a  
24    nurse might be in a management position and she may be  
25    2 blocks away, but I believe a capable, experienced,

1     educated, certified surgical technologist is able and  
2     capable of managing that suite and that patient care  
3     for optimal patient care.

4                     Thank you very much and have a great day.

5                     MR. HOWELL:   Sandra Luthie.

6                     MS. LUTHIE:   Good morning.   I am Sandra  
7     K. Luthie.   I'm a certified surgical technologist  
8     currently working at the University of Virginia Medical  
9     Center.

10                    I have been a surgical technologist for  
11    25 years.   I have precepted teaching nurses, techs,  
12    even medical students at times what to do and how to  
13    scrub and how we do things in the operating room.   I  
14    have always been taught that the operating room is like  
15    a ballet, everybody has a part, everybody does their  
16    part, and everything comes out beautifully in the end.  
17    You get the applause, whether from the family or just  
18    our own satisfaction that you have done your job.

19                    I have been able to do every and any case  
20    at any time.   We work very hard.   We have been trained  
21    very well, and I truly believe that it is time that we  
22    are licensed or registered in the State of Virginia.

23                    Thank you very much.

24                    MR. HOWELL:   Thank you.   We have had a  
25    special request for a change order slightly.   That's

1 Dr. Jones to speak.

2 DR. JONES: Good morning, Mr. Chairman  
3 and other members of the board. I'm Dr. James E.  
4 Jones, Jr. I'm currently practicing OB/GYN at St.  
5 Mary's Hospital. I'm a clinical instructor at MCV in  
6 the Department of OB/GYN, I'm Air Force retired, and  
7 clinical instructor at the University of Utah School of  
8 Nursing.

9 I work with surgical assistants every  
10 day, and I see the need for regulation. I want to know  
11 that the person across from me on that operating room  
12 table is qualified to be there and to be able to help  
13 me in an emergency. Now most of the cases that I do  
14 with the surgical assistants are cases in obstetrics  
15 are mainly Cesarean sections in the OR up in the  
16 Cesarean section suite, and while Cesarean sections can  
17 be a routine kind of procedure, they can quickly  
18 devolve into an emergency because of bleeding or  
19 whatever, and it is very important for me and for my  
20 colleagues who work with surgical assistants to know  
21 that the person that's across from me is not just a  
22 retractor holder, that this person has an expertise and  
23 is to be regulated and we know exactly what their  
24 capabilities are and we can proceed with the cases.

25 There have been many cases in the suite

1 at St. Mary's where we have had nursing, nurses  
2 assisting me with surgical cases. I don't have  
3 anything against nurses, but nurses are not trained  
4 surgical assistants, and we need to have certified  
5 surgical assistants to help in surgical cases, people  
6 who are almost as qualified as physicians for doing  
7 those particular cases.

8 I don't think that we need to go down  
9 this road of surgical assistants being sidekicks or  
10 just people who sort of come in off the street and say  
11 I want to surgical assist. We have been through that  
12 in Utah. We had problems with nurse midwives who just  
13 hung up a sign saying I want to be a nurse midwife, and  
14 there were fatalities and morbidity that I think we  
15 could have avoided.

16 I think certifying and regulating these  
17 people will do great things for the medical care of our  
18 people here in Virginia, the Commonwealth of Virginia,  
19 and in this country.

20 Thank you.

21 MR. HOWELL: Stephen Balog.

22 MR. BALOG: My name is Stephen Balog.

23 I'm a perioperative registered nurse. I have my  
24 Master's of Science in Nursing Administration and I'm  
25 certified in the operating room. I'm also the chair of

1 the Virginia Council of Perioperative Registered Nurses  
2 representing over 1300 registered nurses in Virginia.  
3 I'm currently working as a Clin 5 which is a clinical  
4 ladder, the highest rating in the operating room in a  
5 cardiovascular operating room at the Virginia Hospital  
6 Center in Arlington, Virginia.

7 I have worked in the operating room for  
8 31 years, 28 as a perioperative registered nurse, 3  
9 years as a LPN surgical technologist. I have held  
10 positions as scrub nurse to the director of surgical  
11 services.

12 I want to thank you all for letting me  
13 come speak today and to present testimony on this very  
14 important effort to evaluate the emerging role of the  
15 surgical technologist in Virginia. Our comments today  
16 and the statements for the record that we submitted in  
17 a letter dated July 6, 2009 are based on our  
18 experiences as perioperative registered nurses working  
19 with surgical technologists toward a goal of patient  
20 safety.

21 Our concern with the potential for public  
22 harm underscores our comments as we are guided by the  
23 policies of our national organization, the Association  
24 of Perioperative Registered Nurses, AORN. As you  
25 evaluate the potential risk for harm to the consumer,

1 we encourage you to consider certification as it  
2 requires a minimum level of competency but also  
3 recognizes that the emerging function of surgical  
4 technologists is not a practitioner that can practice  
5 independently. Licensure is inappropriate. However,  
6 in the description of voluntary certification on page  
7 46 of the summary, it states that the scope of practice  
8 is not restricted and that certification does not  
9 restrict the performance of duties only to those  
10 certified. We counsel caution on these terms as we  
11 consider practice too enabling or potentially expansive  
12 and prefer range of function. Moreover we believe that  
13 the scope of practice should be specifically limited to  
14 those identified on page 11 with the exception that  
15 number 3, the reference to medications, needs to be  
16 clarified further.

17               The range of function of the surgical  
18 technologist is distinguishable from the registered  
19 nurse as indicated on page 5 of the summary, and it  
20 states in the State of Virginia a registered nurse must  
21 act as circulator and the registered nurse may not  
22 delegate tasks associated with the circulating role,  
23 limiting the surgical technologist to the role of scrub  
24 person. We might add that the summary contains  
25 references that are not consistent with the above

1 statement, and therefore for purposes of clarification  
2 such incorrect references should be corrected prior to  
3 finalizing the staff summary report.

4 To summarize our recommendations, I have  
5 5. Clarify throughout the summary of staff research to  
6 be consistent with: In the State of Virginia a  
7 registered nurse must act as circulator and a  
8 registered nurse may not delegate tasks associated with  
9 the circulator role, limiting the surgical  
10 technologists to the role of scrub person that is  
11 identified on page 5, clarify the scope of the practice  
12 on page 11 to be restated as range of function as this  
13 term is recommended from the glossary from the National  
14 Council of State Boards of Nursing. The function  
15 listed in number 3 should be clarified such that  
16 medications can be transferred but not administered.  
17 The section on circulating surgical technologist  
18 functions should be delegated -- or should be deleted  
19 except to restate the sentence in Virginia a registered  
20 nurse must function as circulator and may not delegate  
21 circulator duties.

22 Number 3, AORN and AST policy disagree on  
23 the independence of surgical technologists and the need  
24 for the surgical technologists to be supervised by the  
25 registered nurse. AORN policy consistent with Medicare

1 conditions for coverage, for facility policy that is  
2 compliant with Medicare, and with the table one in the  
3 summary all identify the need for the registered nurse  
4 to supervise the surgical technologist.

5 The Virginia Council of Operating Room  
6 Nurses supports certification of the surgical  
7 technologist function that is consistent with AORN  
8 legislative principles to be used in evaluating allied  
9 health legislative initiatives.

10 And number 5, we would recommend that the  
11 review of the surgical technologist and the surgical  
12 assistant needs to be separated. These 2 groups of  
13 allied health personnel perform completely different  
14 functions and they should not be compared and  
15 contrasted in the same document.

16 I also would like to submit for the  
17 record the AORN position statement on surgical  
18 technologists, the AORN legislative principles  
19 regarding allied health personnel, the AORN position  
20 statement on the role of the scrub person, and the AORN  
21 glossary of terms for legislative principles of allied  
22 health legislation.

23 Thank you for letting me speak today. I  
24 appreciate it.

25 MR. HOWELL: Thank you. You are going to

1 make a copy of that script for our staff?

2 MR. BALOG: I will.

3 MR. HOWELL: Next is Bonnie Vencill.

4 MS. VENCILL: My name is Bonnie Vencill.

5 I'm an RN, I work in an OR, and I'm a Legislative State  
6 Coordinator for Virginia and D.C. I'm a member of both  
7 the Virginia Council of Perioperative Registered  
8 Nurses, VCORN, and the Association of Perioperative  
9 Registered Nurses, AORN.

10 I'm currently employed at Southside  
11 Regional Medical Center in Petersburg, Virginia in the  
12 operating room, I have 30 years of perioperative  
13 nursing experience.

14 Thank you for allowing Steve and I to  
15 participate in this very important issue concerning  
16 certification of surgical technologists and surgical  
17 assistants. Our letter dated July 6, 2009 has been  
18 forwarded and received by the Board of Health  
19 Professions.

20 The surgeon, anesthesiologist, surgical  
21 assistant, scrub technologist, and circulating  
22 registered nurse all work together as a team to insure  
23 the safe environment and best outcome for each of our  
24 patients in the operating room. We do believe that  
25 surgical technologists should be graduates of

1 accredited education programs and/or have successfully  
2 completed a national specialty certification process.  
3 This will provide that the scrub delegated roles are  
4 filled with qualified and capable staff. To this end  
5 we also believe the perioperative registered nurse or  
6 circulating nurse by her credentials, education, and  
7 experience must remain as the patient's advocate and  
8 insure each patient's safe outcome. The professional  
9 registered nurse must oversee the entire surgical  
10 process and anticipate the needs for each surgical  
11 patient and case.

12 In Virginia, a registered nurse must  
13 function as circulator and may not delegate circulator  
14 duties. AORN and AST policy disagrees on the  
15 independence of surgical technologists and the need for  
16 the surgical technologists to be supervised by the  
17 registered nurse. AORN policy consistent with Medicare  
18 conditions for coverage, facility policy as compliant  
19 with Medicare, all identify the need for the registered  
20 nurse to supervise the surgical technologists. VCORN  
21 is concerned with the potential for public harm and  
22 does support certification of the surgical technologist  
23 function that is consistent with the AORN legislative  
24 principles to be used in evaluating allied health  
25 legislative initiatives.

1                   In conclusion we are guided by the  
2 policies of our national organization, the Association  
3 of Perioperative Registered Nurses.

4                   If you have any further questions or need  
5 any other information, please feel free to contact me.

6                   Thank you.

7                   MR. HOWELL: All right, thank you.

8                   Becky Bowers-Lanier.

9                   MS. BOWERS-LANIER: Good morning. Thank  
10 you for the opportunity of presenting on behalf of the  
11 Virginia Nurses Association. We are pleased to provide  
12 comment on the need to regulate surgical assistants and  
13 technologists.

14                   The VNA represents the interests of  
15 Virginia's 86,000 registered nurses, and I bring you  
16 comments on behalf of Shirley Gibson, our board  
17 president, and our board of directors.

18                   Given the complexity of surgery as it is  
19 currently performed in hospitals and military surgical  
20 centers and dental, physician, and podiatric offices  
21 and the potential for public harm, VNA supports some  
22 form of regulation of surgical technologists, which we  
23 believe would be appropriate at the level of mandatory  
24 certification.

25                   We base our comments on the findings in

1 the DHP research summary which addresses both the  
2 potential for public harm and the overlap of roles and  
3 scopes of practice among the many members of the  
4 surgical team. This latter factor, the overlap of  
5 roles in scopes of practice would require unneeded  
6 precision in carving out a unique scope of practice for  
7 the technologist should the board decide to move in the  
8 direction of licensure. Mandatory certification,  
9 however, would obviate the need of statutorily defining  
10 a scope of practice but would require procedures for  
11 discipline in the event of threat of public harm.

12 VNA is also sensitive to the  
13 credentialing processes that already take place in  
14 hospitals and ambulatory surgical centers. These  
15 processes verify the competencies of members of  
16 surgical teams including surgical technologists. The  
17 credentialing process might negate the need for  
18 mandatory certification; however, surgeries also take  
19 place in medical, dental, and podiatric offices, and  
20 there are no requirements for credentialing surgical  
21 team members in these offices. Requiring certification  
22 would insure some level of public protection.

23 At this time VNA takes no position on the  
24 need to regulate surgical assistants. Thank you.

25 MR. HOWELL: Excuse me, I'm not sure if I

1 have a question for you or staff, actually for staff,  
2 then I'd like to hear your comment about is there  
3 anybody with mandatory certification in our department?

4 DR. CARTER: The question I have is you  
5 said your association has no position on the need to  
6 regulate?

7 MS. BOWERS-LANIER: Regulate surgical  
8 assistants, but we do have a position on surgical  
9 technologists.

10 DR. CARTER: Thank you.

11 MR. HOWELL: Thank you.

12 Julie Vaughn.

13 MS. VAUGHN: Good morning. My name is  
14 Julie Vaughn, and I carry many titles. First of all I  
15 am a minister at First Baptist of South Richmond.  
16 Dwight Jones is my pastor. I'm also a surgical  
17 technologist at Johnston-Willis Hospital. I am a  
18 licensed surgical technologist from Washington state,  
19 and in that state they require surgical technologists  
20 to be licensed. I have been licensed now since 2001.

21 I have heard many of the reports this  
22 morning on surgical technologists being licensed. I  
23 would say today that we do need to have people in the  
24 operating room that are licensed. Licensed means that  
25 when you are licensed you will, you will submit your

1 paperwork every year on your birth date.

2 When I moved to Richmond, Virginia August  
3 of 2005, I contacted the Board of Health first of all  
4 just like you do when you get your driver's license to  
5 transfer. When I went to transfer, there was nothing  
6 to transfer. When I went to my job, on my job it just  
7 said surgical services. I was shocked. I didn't know  
8 why don't they give you a title? Then I found out that  
9 nobody has a title. I was, I was just totally shocked  
10 because I'm like how could you work in a hospital and  
11 not have a title? If you are a nurse's aid, like I'm  
12 also a nurse's aid, if you contact the Board of Health  
13 in the Commonwealth, my name will come up as Julia  
14 Vaughn. My name will come up as being active. I have  
15 been able to transfer.

16 My complaint is if you come from another  
17 state and you are already licensed, why can't you come  
18 to this state and be licensed? There needs to be a  
19 standard where when you come to Virginia, you can come  
20 and transfer that licensure, so I'm all in favor of  
21 being licensed.

22 I'm also in favor of the accrediting of  
23 schools. If you are going to go to school, go to a  
24 school that gives you a curriculum, one that has  
25 anatomy and physiology, one that teaches you

1 microbiology, one that teaches you ethics, because if  
2 you know ethics, you know what the law states. You  
3 know you can't come in and operate if you don't have  
4 credentials. I mean I'm a patient advocate, I'm for  
5 the patient, and if you are for the patient, you need  
6 to do what is right, and I approve of all those here  
7 today that were for certification and they were for  
8 licensure. That's the only way we are going to make a  
9 change.

10 When I said 3 years ago when we had a  
11 symposium down at VCU, I wrote a proposal that was 13  
12 pages long. I was then in favor of certifying surgical  
13 technologists and surgical assistants and I'm still in  
14 favor of that.

15 I would say to the one who just spoke  
16 about surgical assistants not being certified, I would  
17 say this, we have people that come from China, that  
18 come from Iran, that come in with no credentials. If I  
19 ask them a question like right now I'm sitting to take  
20 the examination, what was so and so and so and so, they  
21 could not answer, but yet still they don't want to be  
22 certified, so if you are going to certify, take a look  
23 at all who are in the room. Don't execute anyone. Ask  
24 the patients of each one. If you can't pass the test,  
25 get another job. This job is for people who want to

1 be, who want to be credible. I mean you have to have  
2 the credibility of what you are doing. I wouldn't go  
3 to a hairdresser that didn't have a title up on the  
4 door that says that I'm a hair dresser. I wouldn't go  
5 to a dental office and sit in that chair if he didn't  
6 have any type of accreditation showing me he was a  
7 dentist. I wouldn't go to a doctor's office if he  
8 didn't have anything behind him telling me that he was  
9 a surgeon.

10 The same thing when I'm in my mask, you  
11 need to know that I'm certified. You need to know that  
12 I'm licensed. You need to be able to put on the  
13 computer, pull up my name when I'm at your interview,  
14 you say you are what, you say you are who? And you  
15 should be able to see on the screen whether I'm  
16 credentialed, and I'm thankful that I came from a state  
17 of Washington state who is one of the one states out of  
18 5 who mandatory licensure. I'm thankful for that. The  
19 road was rough, the times were hard, but one thing  
20 about it was that we made it all and we can stand here  
21 and say now that we are proud, we are proud to be  
22 licensed surgical technologists, and I'm pretty sure  
23 everybody in this room that agree with me would say the  
24 same thing, so I will continue to say that keep your  
25 eyes open and allow us to be certified and licensure

1 because it would only bring out great things.

2 Another thing I would say is Medicare in  
3 Washington state, if you are not certified, Medicare  
4 won't pay. And we are having a problem right now.  
5 People talk about insurance companies. Well, the  
6 insurance companies are pretty soon going to tell you  
7 well, we are not going to pay, you are not licensed,  
8 you didn't come from an accredited school, that will be  
9 the next step, so we need to take a look at that.

10 Thank you very much.

11 MR. HOWELL: Thank you. Next on the list  
12 is Dr. Montero.

13 DR. MONTERO: Can I yield my slot right  
14 now to Dr. McBee before I talk?

15 MR. HOWELL: That's fine.

16 DR. MCBEE: Good morning. My name is  
17 Matthew McBee. I'm a resident of Windsor, Virginia.  
18 I'm a practicing surgeon at Sentara Obici Hospital in  
19 Suffolk as well as Maryview Medical Center in  
20 Portsmouth, Virginia.

21 My practice is broad and it encompasses  
22 both general surgery, vascular surgery, and thoracic  
23 surgery. I'm board certified in vascular surgery as  
24 well as general surgery. At those 2 facilities I  
25 conduct somewhere between 2,000 and 2,500 operations a

1 year. I have intimate contact with surgical  
2 assistants, I know their skill level, I do participate  
3 in some degree with their training as they rotate  
4 throughout our facilities through EVMS.

5 I'm here today to voice support for the  
6 Virginia state licensure for non physician surgical  
7 assistants. As a surgeon, patient safety, successful  
8 outcomes are essential for our surgical procedures.  
9 Properly trained and educated surgical assistants  
10 provides me and my patients the best opportunity to  
11 insure successful outcomes.

12 As you know, in the last 4 or 5 years the  
13 surgical arena, the medical arena for that matter has  
14 changed dramatically in that we are trying very  
15 desperately to cut down our health care costs. This  
16 will ultimately occur, but it cannot occur at the  
17 expense of patient safety and patient care.

18 15, 20 years ago when I first started,  
19 any moderately sized operative procedure and certainly  
20 a major surgical procedure, we were assisted with a  
21 partner, 2 physicians present at the bedside. That  
22 practice has gone away. I don't see that occurring  
23 very much any more. It's one of reimbursements  
24 dropping and it's not financially feasible to do that  
25 any more. That means we are going to be relying upon

1 physician extenders, surgical assistants, surgical  
2 techs, people that will have expertise in other areas  
3 that will help us, that will not mandate we have to  
4 have 2 physicians in the room at the same time. The  
5 good news about that is that the majority of the  
6 primary surgeons are not very good assistants. We make  
7 good surgeons, we are not such good assistants. The  
8 assistants we are turning out now from our accredited  
9 programs are in my opinion superior to the surgeon.

10                   There is, however, at present a lack of  
11 requirements that stipulate what constitutes a surgical  
12 assistant. It is my opinion I believe that there needs  
13 to be a set didactic curriculum for which all the  
14 assistants participate. There needs to be a set fixed  
15 clinical rotation of exposure to various specialties  
16 that each one must participate and complete  
17 successfully, and ultimately I'd like to see these same  
18 individuals become licensed.

19                   In the course of my 2 decade surgical  
20 career, I have operated with surgical residents,  
21 physician assistants, nurse practitioners as well as  
22 surgical assistants. The confidence that I have in my  
23 surgical assistants is extremely important. It allows  
24 me to focus on the task at hand which is to perform the  
25 surgery, not to conduct a how to, provide exposure, not

1     which instruments you need, et cetera.

2                     The other importance of this is that the  
3     assistants certainly facilitate our ability to do our  
4     job and that they decrease the amount of surgical time  
5     that we are in the operating arena, also decrease the  
6     amount of anesthesia that our patients are exposed to,  
7     and I think these are good things in that it lowers our  
8     risk to the patient, also lowers cost.

9                     I believe the licensing in Virginia of  
10    non physician surgical assistants is, the licensing of  
11    them is long overdue. It would inspire our surgeons,  
12    patients, and their families with the same confidence I  
13    expect from the health care professionals that assist  
14    me in surgery. I as a physician in Virginia am  
15    required to be licensed in the State of Virginia. I'm  
16    also at my hospital required to be board certified in  
17    each of the surgeries I participate. I don't see why  
18    we would hold the other health care providers in the  
19    operating room to any less standards.

20                    The duties of the surgical assistants are  
21    extremely important for a positive outcome of surgical  
22    procedures, and state licensure would set standards,  
23    education and qualifications and other eligibility  
24    requirements and establish a much needed level of  
25    confidence for both the patient as well as the

1 coworkers in the operating room.

2 Thank you for the opportunity to speak to  
3 this committee this morning. I will take any questions  
4 if there are any.

5 MR. HOWELL: Thank you. Dr. Montero.

6 DR. MONTERO: Good morning. Thank you,  
7 Mr. Howell, for allowing the change.

8 I appear here before you, we'll be  
9 talking again this afternoon at 1:00 o'clock, but I'm  
10 Juan Montero, retired from general and non cardiac  
11 thoracic surgery for 35 years, and since 2 years ago I  
12 still sit on the Board of Medicine and the Board of  
13 Health Professions.

14 I'm here to appear before your committee  
15 on a personal level. I strongly believe that surgical  
16 assistants be regulated and in essence licensed because  
17 of the critical role that they play in the operating  
18 room. And here in Virginia we are very fortunate that  
19 Norfolk General Hospital, they are the pioneer in the  
20 surgical assistant program throughout the nation, and  
21 in fact Mr. Jennette is here being the president of the  
22 National Surgical Assistant Association, that's how  
23 much respect the training program has all over the  
24 country, the one at Norfolk General Hospital, and to  
25 some degree I believe they are also tied up with the

1 Mayo Clinic in Minnesota.

2 I may get into trouble today with  
3 Dr. Britt, but I see it from my personal experience  
4 when I was still practicing in our area, when it comes  
5 to very complicated case, for instance when I talk to  
6 my patient as to which hospital I'd like them to go to,  
7 so happens that the one I practice to, there's no  
8 training program among surgical residency, the surgical  
9 residents don't rotate in our hospital, and so I just,  
10 I tell the patient that I am very comfortable going to  
11 this hospital because of my surgical assistant, I can  
12 be assured and that for this complicated case that you  
13 have, and these people have already seen this many  
14 times with me, that I'll be comfortable doing your case  
15 and, you know, I'm not being prejudiced to training  
16 program hospitals, but in those setting sometimes you  
17 are not assured of who will assist you. First  
18 assistant in some complicated cases, you may end up  
19 with with PG1, we use to call intern before, or PG2,  
20 not the real operative of more trained residents, and  
21 the situation there is this, that even if it's the PG1  
22 or the intern that is assisting your case, that  
23 particular person, even if he doesn't have much  
24 experience, becomes the first assistant. The surgical  
25 assistant, no matter how much experience he has become

1 second assistant because of the training program we do.  
2 I'm not prejudiced to that. I have 2 sons in medicine,  
3 the young son just finished a surgical residency at  
4 Denver, so I just want you to know, and also when it  
5 comes to surgical complications, I would venture to say  
6 that at least 50 percent or 75 percent of that surgical  
7 complication could be related to what was done or what  
8 was not done in the operating room, so that's how  
9 critical the surgical assistants play the role there.

10 And I cannot be any more blunt about the  
11 importance of their regulation with Dr. Britt being on  
12 board, really, a signatory of the petition, that speaks  
13 volumes. He will be the next president of the American  
14 College of Surgeons in the next year or couple of years  
15 from that, so we are very fortunate. Thank you.

16 AUDIENCE MEMBER: Can I ask a question,  
17 please?

18 MR. HOWELL: Not at this time.

19 Theresa Cooper.

20 MS. COOPER: Good morning. My name is  
21 Theresa Cooper. I'm a certified surgical assistant, a  
22 certified first assistant, and also CST. I spoke to  
23 the board a couple times already now, and what I really  
24 want to say today is what everybody says, what it all  
25 comes down to is patient safety. If one of your loved

1 ones, members of the board, was to go to surgery today,  
2 tomorrow, wouldn't you want to know that everybody that  
3 is taking care of them has been to school, they are  
4 educated, they get continuing education, and they are  
5 certified, licensed in whatever they do. Right now  
6 they are not. You know, you could have anyone up at  
7 that table. It's up to the hospitals right now to say  
8 who can scrub, who can't scrub, who they employ, who  
9 they don't employ. You know, what it comes down to, if  
10 they can hire someone at minimum wage, they are going  
11 to get someone at minimum wage. Maybe that person went  
12 to school, maybe they dropped out, who knows? But  
13 that's what's going on. And you people can change  
14 that. You don't want your loved one to go in the  
15 hospital and not knowing who's looking after them. Out  
16 on the floor everybody wears a badge, says who they  
17 are. Come to the operating room, the doctors, the  
18 techs, the nurses, we all look the same, we all wear  
19 the same clothes. You don't know who we are. For  
20 patient safety, for the safety of my loved ones, I  
21 don't want anyone that's not certified, not registered,  
22 not licensed, working on my family member. And I think  
23 if everybody out there knew some of the people that we  
24 have working in these operating rooms, they would be  
25 outraged, and maybe we should go tell everybody who is

1 working in the operating rooms, you know. It's true,  
2 we all know that, you all don't know that, the public  
3 don't know that.

4 And I'd like to thank ARN for one  
5 supporting surgical technologist certification and AST  
6 supports a circulator in every room. I'd also like to  
7 add in the State of Virginia I don't believe any of the  
8 nursing schools teach scrubbing any more in the  
9 operating room, so most of the time any nurse that does  
10 scrub in the operating room in Virginia is taught by a  
11 CST, so supervision of the nurse over the tech  
12 sometimes is a little off, just the fact that they  
13 don't teach that in nursing school.

14 Other than that, that's all I have got to  
15 say. Thank you.

16 MR. HOWELL: Thank you.

17 Mary Armstrong.

18 MS. ARMSTRONG: Good morning. My name is  
19 Mary Armstrong. I am a certified surgical assistant,  
20 certified first assistant, certified surgical  
21 technologist. I'm also president of the Virginia  
22 Commonwealth State Assembly of the Association of  
23 Surgical Technologists, and I'm a legislative board  
24 member of the Virginia Association of Surgical  
25 Assistants.

1                   I come to speak with you guys, I have  
2    been here I guess at every meeting and have given  
3    comment and written as well as verbal, and I really  
4    didn't prepare anything today because I wanted to see  
5    what was going to happen when we got here. I am so  
6    thrilled to see all of these people in the audience  
7    today, surgical techs, surgical assistants, and our  
8    friends, nurses.

9                   In the operating room we all feel that  
10   the patient is best served, their safety is best served  
11   through the presence of everyone, RNs, surgical  
12   assistants, and surgical technologists. We have no  
13   argument there. We don't want to take each other's  
14   roles, each other's positions. We want patient safety.  
15   We want education. There are surgical technologists  
16   out there with 2 year degrees, there are surgical  
17   assistants out there with 4 year degrees, there are  
18   nurses out there with 2 year degrees, 4 year degrees,  
19   and 3 year diplomas, so education should not be argued  
20   here. That is what we want through mandatory  
21   certification, licensure, registration. Whatever the  
22   outcome is, we want that education there. It is  
23   important to all aspects of patient care.

24                  The need for regulation has come from the  
25   fact that there are people in the operating room who

1 are not educated, who do not maintain advanced  
2 practice, they do not keep up continuing education. By  
3 mandatory regulation through the state, we will  
4 guarantee everyone who operates on our loved ones, on  
5 our public will have a minimum education, they will  
6 have to keep up CEUs, they will have to keep  
7 certifications. That is all that we want. We don't  
8 want to take each other's jobs, we don't want to be the  
9 boss, we don't want to be over top of anybody else, we  
10 just want patient safety and we want that regulated.

11 As was said earlier, if you leave it to  
12 the hospitals to regulate, you leave out a huge chunk  
13 of people. They are not only at dental offices,  
14 podiatrists, plastic surgeons, we have all heard the  
15 things that happen on the news to people who die from  
16 liposuction and face lifts. There are people besides  
17 the surgeon working on you in those offices, so if we  
18 leave it to the hospitals alone to give that  
19 regulation, there will be a large population missed  
20 there.

21 I once again plead to you to please  
22 strongly consider the need for regulation,  
23 certification, registration, licensure, all the  
24 aspects. We all know there's a criteria for the  
25 various types of regulations, but the need is there

1 regardless of what the outcome is. Thank you.

2 MR. HOWELL: Thank you.

3 Cathy Sparkman.

4 MS. SPARKMAN: Members of the committee,  
5 Dr. Carter, thank you again for reconvening a hearing  
6 regarding the registration, licensure, or certification  
7 of surgical technologists and surgical assistants.

8 My name is Catherine Sparkman. I'm  
9 Director of Government and Public Affairs for the  
10 National Association of Surgical Technologists. I too  
11 along with many of my colleagues here have been here  
12 for the last 2 meetings and have submitted extensive  
13 written materials to Justin Crow and to the board, and  
14 I suppose we are not done yet. We have other  
15 information for you. I'm not going to take up much of  
16 your time, but as promised in the last meeting I tried  
17 to develop evidence based decision making for the  
18 board, and I have compiled just one subsection of the  
19 roles of surgical technologists in the operating room  
20 which is the maintenance of the sterile field you all  
21 are very well aware of with the really quite  
22 comprehensive and brilliant draft that has been  
23 prepared of all of the things that surgical  
24 technologists do.

25 I took one line of thought and thought we

1 might be able to develop some evidence on what occurs  
2 in the operating room, so I picked DRG 418 which is  
3 postoperative and post traumatic infections and what  
4 Medicare pays for having surgical site infections,  
5 MRSA, and others, and I went through Virginia hospitals  
6 to determine the number of postoperative surgical  
7 infections, the number of days that that adds to a  
8 patient's stay at a hospital, the amount of money that  
9 is spent on those surgical days, the average and median  
10 charge -- I won't bore you with numbers -- but it is  
11 illuminating and very staggering the amount of money  
12 that does result from the maintenance of or non of the  
13 sterile field in the operating room. Averages range  
14 from 5.9 to 8.8 extra days due to a surgical site  
15 infection costing an average of anywhere from \$3,900 to  
16 \$5,393. If you add that up among the number of  
17 surgical patients in the State of Virginia, and  
18 certainly surgical patients nationally, it becomes a  
19 significant issue only on a monetary basis, setting  
20 aside the personal cost to not having trained personnel  
21 and certified registered or licensed personnel in the  
22 operating room.

23 I have also sent you a, furnished a list  
24 of all of the schools in the State of Virginia, their  
25 contact information, the number of graduates, and to

1 demonstrate how the schools and the educational  
2 institutions in Virginia are addressing the need for  
3 competent and capable surgical technologists in this  
4 state.

5 I also have given you a list of the  
6 surgical assistant and surgical technologist bills  
7 including their sponsors so that you can see the  
8 commitment that certainly the national office of our  
9 Association of Surgical Technologists has to this very  
10 important issue. We are at the present time advancing  
11 bills in 9 states, have passed bills in 2 states in  
12 2009 alone, and we are very serious about it.

13 I also have, am going to furnish, I'm  
14 furnishing letters from the Center for Medicare,  
15 Medicaid services regarding never events and a list of  
16 the never events that Medicare over the next several  
17 fiscal years is going to decline to pay for. Surgical  
18 site infections is one, there are other ones I think we  
19 talked, we discussed this last time. There are 8 never  
20 events identified by CMS. 5 of them occur in the  
21 operating room, and the reduction of those never events  
22 is a matter of clinical -- excuse me, critical federal  
23 importance to the end that Medicare will no longer pay  
24 for these never events that occur in the operating  
25 room.

1 I'm also, and I have their, their letters  
2 and some discussion points from CMS. They weren't  
3 addressed to me, they are obviously national letters,  
4 but they do identify the issues.

5 I am also including an article by Linda  
6 Akin, a registered nurse, which ties educational  
7 qualifications, educational achievement to the  
8 reduction in surgical patient mortality. It is  
9 directed at nurses, it is an illuminating study, and I  
10 submit that the parallels are inexorable. The higher  
11 the educational level, the lower the surgical patient  
12 mortality will be in our operating rooms, and  
13 regulation of surgical technologists and surgical  
14 assistants certainly support and effectuate the kinds  
15 of results in Dr. Akins' study.

16 Finally, I just would like to end with a  
17 story out of my home state in Colorado. There is a  
18 surgical technologist that has had considerable  
19 notoriety in the last several months, a surgical  
20 technologist who is neither certified and of course  
21 completed no credentials and no education, was working  
22 in a hospital in Denver. That surgical technologist  
23 had a drug habit. She would slide into an operating  
24 room, take syringes of fentanyl, self-inject, fill the  
25 syringes with saline, and replace them. That would not

1 be so striking except that the surgical technologist  
2 had hepatitis C, and now dozens of patients, surgical  
3 patients at this hospital are faced with a lifetime of  
4 the diagnosis of hepatitis C. She was not caught, I'm  
5 talking about in a net or in a system that would have  
6 identified past drug use, past convictions for drug  
7 use, including heroin, past experiences at other  
8 facilities, and I'm not saying that a comprehensive,  
9 even a comprehensive system of registration would have  
10 caught this person any more than it catches a nurse or  
11 physician who struggles with drug addiction at the  
12 expense of their patients, but it is a step.

13 We heard about medical and surgical  
14 ethics, we hear about the things that are taught and  
15 impressed upon those who are undergoing those surgical  
16 technologist programs.

17 I bring this up secondarily because the  
18 Department of Regulatory Agency in the State of  
19 Colorado, DORA, has contacted us and has urged us to  
20 submit proposed legislation to regulate surgical  
21 technologists in our state.

22 The time has come, and as has been  
23 eloquently said, patient safety is what all members of  
24 the surgical field are all about. You can choose your  
25 hospital, you can choose your doctor, you can vet them

1 both, you can vet everybody who delivers surgical care.  
2 Once you are asleep you have no idea the rest of the  
3 members of the surgical team. Regulation will  
4 certainly go a long way to helping our patients feel  
5 secure in that situation.

6 Thank you.

7 MR. HOWELL: Thank you. Dr. Matt McBee.

8 Done?

9 We want to thank all who took the time to  
10 come today to offer comments on the study. We will  
11 consider all comments prior to the development of  
12 recommendations concerning further studies. Written  
13 comments will be accepted until 5:00 p.m. on  
14 August 15th.

15 Again, thank you for taking time to  
16 participate in this, and this concludes the hearing.  
17 Thank you.

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20 ---Conclusion---

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## CERTIFICATE OF COURT REPORTER

I, Lynn Aligood, hereby certify that I was the Court Reporter for the public hearing conducted by the Department of Health Professions in re need to license surgical assistants and surgical technologists.

I further certify that the foregoing transcript is a true and accurate record of the hearing to the best of my ability.

Given under my hand this 15th day of August 2009.

  
Lynn Aligood, RMR